Standard INSURANCE COMPANY PORTLAND, OREGON
Dedicated to Excellence

MEDICAL HISTORY STATEMENT

Group Medical Underwriting
900 SW Fifth Ave • Portland OR 97204–1282

Plan Administrator Section USE IN ALL STATES EXCEPT D.C., MD, MI, MO, MN, NV, NY, OH, OR, AND VT. *DIRECTIONS: This form must be completed when Evidence Of Insurability is required under your plan. You complete this section. Give the form to the applicant to read the notice on back, respond to the Applicant Section, and submit to Standard. If both the Member and his/her Dependent(s) (Spouse and/or Child) are applying, each must complete one of these forms.*

NAME OF POLICYOWNER (AS SHOWN ON YOUR GROUP POLICY)	POLICY NUMBER	TYPE OF APPLICATION (CHECK ONE) ☐ INITIAL ☐ INCREASE IN COVERAGE	CHECK APPLICABLE COVERAGE ☐ LTD ☐ STD ☐ LIFE ☐ DEPENDENTS LIFE ☐ ADDITIONAL LIFE ☐ SUPPLEMENTAL LIFE

MEMBER'S NAME	BIRTHDATE	DATE HIRED	IS THIS A LATE APPLICATION?	OCCUPATION	SALARY	SOCIAL SECURITY NUMBER
	/ /	/ /	☐ YES ☐ NO			

Applicant Section *DIRECTIONS: To apply for coverage (as a Member, Spouse or Child), read the Information Practices Notice on back of this form. Then complete, sign, and date all items below. When finished, send the top three copies to Standard Insurance Company, and keep the last copy (goldenrod) for your records.*

CHECK WHO IS APPLYING (ONE PER FORM) ☐ MEMBER ☐ SPOUSE ☐ CHILD	APPLICANT'S NAME (PERSON TO BE INSURED)	APPLICANT'S ADDRESS (Street ,City, State, Zip)

SEX ☐ M ☐ F	BIRTHDATE / /	BIRTHPLACE	SOCIAL SECURITY NUMBER	WORK PHONE ( ) - HOME PHONE ( ) -

ADDITIONAL LIFE APPLICANTS:

PLAN OPTION (IF APPLICABLE): _____

AMOUNT OF COVERAGE REQUESTED:

$ _____

SUPPLEMENTAL LIFE APPLICANTS:

AMOUNT OF COVERAGE REQUESTED: $ _____

($10,000 increments; $30,000 minimum, $300,000 maximum, subject to the Group Policy and state limitations.)

IF REQUESTING AN INCREASE IN COVERAGE:

TOTAL AMOUNT NOW INFORCE: $ _____

INCREASED INCREMENT REQUESTED: $ _____

BENEFICIARY DESIGNATION: If you currently have a beneficiary designation on file with your plan administrator for Life coverage under Standard's Group Policy, that designation will also apply to any approved Additional or Supplemental Life, or other coverage increase. If you have no beneficiary designation on file or wish to change the name of the current designee, contact your plan administrator.

For approved applicants, premiums shall be paid in accordance with the provisions of the Group Policy(ies). Declinations do not affect either Guarantee Issue Amounts not subject to Evidence Of Insurability or other coverages already inforce with Standard Insurance Company. Coverage will be subject to all terms and conditions of the Group Policy(ies) and state limitations.

SHADED AREA FOR INSURANCE COMPANY USE ONLY

☐ APPROVED DATE ___/___/___	☐ DENIED DATE ___/___/___	☐ DENIED DUE TO LACK OF INFORMATION DATE ___/___/___
MEDICAL UNDERWRITER SIGNATURE	MEDICAL UNDERWRITER SIGNATURE	EVIDENCE PROCESSOR SIGNATURE

HEIGHT	WEIGHT	PHYSICIAN OR MEDICAL FACILITY WITH APPLICANT'S COMPLETE MEDICAL RECORDS NAME	FULL MAILING ADDRESS	MEMBERSHIP NUMBER

Check yes or no for each of these questions, and give details for any "yes" answers after #10. (Attach a separate sheet if more room is required.)

1. Have you had any physical, mental or emotional condition, injury, sickness, or surgery in the past 5 years? ☐ Yes ☐ No
2. Have you consulted or been attended by a physician or practitioner for any cause in the past 5 years? ☐ Yes ☐ No
3. Are you now unable to work full time because of any physical, mental or emotional condition, injury, or sickness? ☐ Yes ☐ No
4. Has a medical professional ever treated you for, diagnosed you as having, or prescribed medication for you for any of the following:
   - A. High blood pressure, cardiovascular disease, heart ailment, arteriosclerosis, or stroke? ☐ Yes ☐ No
   - B. Mental condition, depression, epilepsy, or nervous system disorder? ☐ Yes ☐ No
   - C. Cancer, diabetes, or nephritis? ☐ Yes ☐ No
   - D. Arthritis, strained or injured back, slipped disc, or any bone, joint, or muscle disorder? ☐ Yes ☐ No
   - E. Lung, kidney, stomach, genital, urinary, or intestinal ailment? ☐ Yes ☐ No
   - F. Blindness or deafness? ☐ Yes ☐ No
   - G. Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or an immune system disorder? ☐ Yes ☐ No
5. Have you sought or received advice or treatment for the use of alcohol or drugs in the past 10 years? ☐ Yes ☐ No
6. In the past 10 years have you had a persistent cough, unintentional weight loss of 10 pounds or more, persistent fatigue, persistent lymph node enlargement, prolonged night sweats, pneumonia, lesions, or growths? ☐ Yes ☐ No
7. Do you take medication for any physical, mental or emotional condition, injury, or sickness? ☐ Yes ☐ No
8. Do you plan any operation or visit to a doctor or practitioner for an existing physical, mental or emotional condition, injury, or sickness? ☐ Yes ☐ No
9. Have you ever been declined for insurance or offered a rated or restricted policy, either as a new policy or reinstatement? ☐ Yes ☐ No
10. Are you now pregnant? ☐ Yes ☐ No

#	*Description of Injuries, Disorders and Operations*	*Month/Year*	*Duration*	*Final Result*	*Physicians Consulted, City & State*

Acknowledgment and Authorization for Release of Information. (Please read carefully.)

I represent that the statements contained herein are true and complete, to the best of my knowledge and belief, and I understand that they form the basis of any coverage under the Group Policy(ies). I understand that any misstatements or failure to report information which is material to the issuance of coverage may be used as a basis for rescission of my insurance and/or denial of payment of a claim. I agree to notify Standard Insurance Company of any change in my medical condition while my enrollment application is pending. I agree that if my application is approved by Standard, the effective date of any coverage will be determined in accordance with the terms of the Group Policy(ies), including any applicable Active Work requirement. I agree that if my application is declined, Standard's liability is limited to the return of any premium which may have been paid.

I acknowledge that I have read and received the Information Practices Notice (on the back of the form) and I have received a copy of this Medical History Statement.

To any physician, health care provider, hospital, insurance or reinsurance company, the Medical Information Bureau, Inc. (MIB), or any employer: I authorize you to release to Standard or its reinsurers all medical information you have about me including medical history, diagnosis, prognosis and treatment of any physical, mental or emotional condition. I understand that Standard will use the information obtained by this authorization to determine my eligibility for group insurance coverage. I further authorize Standard to release this information to its reinsurers, MIB, and to other insurance companies to which I have applied for insurance coverage or benefits.

I understand a copy of this authorization will be provided upon request. This authorization will remain valid one year from the date below. A photocopy of this authorization shall be as valid as the original.

SIGNATURE OF APPLICANT (OR MEMBER FOR DEPENDENT CHILD) _____ **DATED** _____

Send the top three copies to Standard Insurance Company (address at top of form); and retain last copy (goldenrod) for your records.

STANDARD INSURANCE COMPANY

Important:
For Use In All States except D.C., MD., MI., MO., MN., NV., N.Y., OH., OR., VT.

HOW TO COMPLETE YOUR MEDICAL HISTORY STATEMENT

In order to avoid delay in processing your Medical History Statement please complete all sections of attached form (Note: circled areas are most commonly omitted.)

Plan Administrator Section: (Must be completed by Employer.)

Legal name of Group Policyowner and six digit policy number.

Applicant Section: (Must be completed by applicant. Please be sure all boxes are completed.)

Only complete the Additional and/or Supplemental Life Sections if your plan includes these coverages and you wish to apply.

Do not write in this shaded area.

Height and Weight must be included.

All questions must be answered "Yes" or "No".

Please use an extra sheet of paper if necessary.

Standard Insurance Company, Portland, Oregon — Dedicated to Excellence

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NAME OF POLICYOWNER (AS SHOWN ON YOUR GROUP POLICY) | POLICY NUMBER | TYPE OF APPLICATION (CHECK ONE) ☐ INITIAL ☐ INCREASE IN COVERAGE | CHECK APPLICABLE COVERAGE ☐ LTD ☐ STD ☐ LIFE ☐ DEPENDENTS LIFE ☐ ADDITIONAL LIFE ☐ SUPPLEMENTAL LIFE

MEMBER'S NAME | BIRTHDATE / / | DATE HIRED / / | IS THIS A LATE APPLICATION? ☐ YES ☐ NO | OCCUPATION | SALARY | SOCIAL SECURITY NUMBER

Applicant Section *DIRECTIONS: To apply for coverage (as a Member, Spouse or Child), read the Information Practices Notice on back of this form. Then complete, sign, and date all items below. When finished, send the top three copies to Standard Insurance Company, and keep the last copy (goldenrod) for your records.*

CHECK WHO IS APPLYING (ONE PER FORM) ☐ MEMBER ☐ SPOUSE ☐ CHILD | APPLICANT'S NAME (PERSON TO BE INSURED) | APPLICANT'S ADDRESS (Street, City, State, Zip) *1

SEX ☐ M ☐ F | BIRTHDATE / / | BIRTHPLACE | SOCIAL SECURITY NUMBER | WORK PHONE ( ) HOME PHONE ( ) *2

ADDITIONAL LIFE APPLICANTS:
PLAN OPTION (IF APPLICABLE): _____
AMOUNT OF COVERAGE REQUESTED: $ _____

SUPPLEMENTAL LIFE APPLICANTS:
AMOUNT OF COVERAGE REQUESTED: $ _____
($10,000 increments; $30,000 minimum, $300,000 maximum, subject to the Basic Policy applicable limitations.)
IF REQUESTING AN INCREASE IN COVERAGE:
TOTAL AMOUNT NOW INFORCE: $ _____
INCREASED INCREMENT REQUESTED: $ _____

BENEFICIARY DESIGNATION: If you currently have a beneficiary designation on file with your plan administrator for Life coverage under Standard's Group Policy, that designation will also apply to any approved Additional or Supplemental Life, or other coverage increase. If you have no beneficiary designation on file or wish to change the name of the current designee, contact your plan administrator.

For approved applicants, premiums shall be paid in accordance with the provisions of the Group Policy(ies). Applications do not affect either Guarantee Issue Amounts not subject to Evidence Of Insurability or other coverages already inforce with Standard Insurance Company. Coverage will be subject to all terms and conditions of the Group Policy(ies) and state limitations.

SHADED AREA FOR INSURANCE COMPANY USE ONLY

☐ APPROVED DATE ___/___/___ | ☐ DENIED DATE ___/___/___ | ☐ REFERRED DUE TO LACK OF INFORMATION DATE ___/___/___

MEDICAL UNDERWRITER SIGNATURE | MEDICAL UNDERWRITER SIGNATURE | EVIDENCE PROCESSOR SIGNATURE

HEIGHT | WEIGHT | PHYSICIAN OR MEDICAL FACILITY WITH APPLICANT'S COMPLETE MEDICAL RECORDS *3
NAME | FULL MAILING ADDRESS | MEMBERSHIP NUMBER

Check yes or no for each of these questions, and give details for any "yes" answer in item #10. (Attach a separate sheet if more room is required.)

1. Have you had any physical, mental or emotional condition, illness, surgery in the past 5 years? ☐ Yes ☐ No
2. Have you consulted or been attended by a physician or practitioner in the past 5 years? ☐ Yes ☐ No
3. Are you now unable to work full time because of any physical, mental or emotional condition, injury, or sickness? ☐ Yes ☐ No
4. Has a medical professional ever treated you for, diagnosed you as having, or prescribed medication for you for any of the following:
   - A. High blood pressure, cardiovascular disease, heart ailment, arteriosclerosis, or stroke? ☐ Yes ☐ No
   - B. Mental condition, depression, epilepsy, or nervous disorder? ☐ Yes ☐ No
   - C. Cancer, diabetes, or nephritis? ☐ Yes ☐ No
   - D. Arthritis, strained or injured back, slipped disc, any bone, joint, or muscle disorder? ☐ Yes ☐ No
   - E. Lung, kidney, sexual, genital, urinary tract, or prostate ailment? ☐ Yes ☐ No
   - F. Blindness or eye disease? ☐ Yes ☐ No
   - G. Acquired Immune Deficiency Syndrome (AIDS), AIDS–Related Complex (ARC), or an immune system disorder? ☐ Yes ☐ No
5. Have you sought or received treatment for the use of alcohol or drugs in the past 10 years? ☐ Yes ☐ No
6. In the past 10 years, have you been diagnosed as having, or been treated by a physician for, unintentional weight loss of 10 pounds or more, persistent fatigue, persistent fever, enlarged lymph glands, prolonged night sweats, pneumonia, lesions, or growths? ☐ Yes ☐ No
7. Do you take medication for any physical, mental or emotional condition, injury, or sickness? ☐ Yes ☐ No
8. Do you plan any operation or visit to a doctor or practitioner for an existing physical, mental or emotional condition, injury, or sickness? ☐ Yes ☐ No
9. Have you ever been declined insurance or offered a rated or restricted policy, either as a new policy or reinstatement? ☐ Yes ☐ No
10. Are you now pregnant? ☐ Yes ☐ No

#	Description of Injuries, Disorders and Operations *4	Month/Year	Duration	Final Result	Physicians Consulted, City & State

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I represent that the statements contained herein are true and complete, to the best of my knowledge and belief, and I understand that they form the basis of any coverage under the Group Policy(ies). I understand that any misstatements or failure to report information which is material to the issuance of coverage may be used as a basis for rescission of my insurance and/or denial of payment of a claim. I agree to notify Standard Insurance Company of any change in my medical condition while my enrollment application is pending. I agree that if my application is approved by Standard, the effective date of any coverage will be determined in accordance with the terms of the Group Policy(ies), including any applicable Active Work requirement. I agree that if my application is declined, Standard's liability is limited to the return of any premium which may have been paid.

I acknowledge that I have read and received the Information Practices Notice (on the back of the form) and I have received a copy of this Medical History Statement.

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I understand a copy of this authorization will be provided upon request. This authorization will remain valid one year from the date below. A photocopy of this authorization shall be as valid as the original.

SIGNATURE OF APPLICANT (OR MEMBER FOR DEPENDENT CHILD) *5 | DATED

Send the top three copies to Standard Insurance Company (address at top of form); and retain last copy (goldenrod) for your records.

SI–18–7001 (3/97)

SAMPLE

Full Signature is required and application must be dated.

***1.** A separate form must be completed by each Member, Spouse or Child requesting coverage.

***2.** Include both your WORK and HOME phone numbers. If we need to have additional information, this will make it easier for us to reach you.

***3.** Use complete name and mailing address of the physician or facility that has your medical records. If you know your chart, clinic or medical plan membership number, please provide this to help us identify your records. If you have consulted any other physicians, please include their names and mailing addresses.

***4.** Provide full details to any "yes" answer in the space provided. Use a separate sheet of paper if necessary. Include dates, treatment and final results.

***5.** Sign and date the authorization and retain the lower portion of the last copy of the form for your records. Send the top three copies excluding this instruction page to:

Standard Insurance Company
Group Medical Underwriting
900 S.W. 5th Avenue
Portland, Oregon 97204–1282

QUESTIONS ABOUT COMPLETING THIS APPLICATION? Call 1-800-843-7979

In order to evaluate your application, we are relying on the information you have provided. In addition, we may need to request supplemental information from you or your doctor. We may also require a brief examination, blood test and urinalysis. Should these tests be necessary, they will be requested by Standard. You will receive notification if additional information is needed.